Reimbursement Request Form

Lifetime BENEFIT SOLUTIONS

Employer Name: University of Rochester

Participant Name (First, MI, Last): _____

Social Security Number: _____ - _____ - _____

Address: _____

City, ST, ZIP: _____

Date of Birth: _____/_____/_____ Phone Number (_____) _____

Please notify your employer of any address change. Lifetime Benefit Solutions will not make address changes from this form.

Claimant Name	Date of Service	Amount	Plan Code*	Type of Service/Item Purchased	# of Miles	Claim Ref #
John Sample	*10/1/2014*	*$ 150.25*	*F*	*Doctor visit copay*	*12*	*Example*
		$				01
		$				02
		$				03
		$				04
		$				05
		$				06
		$				07
		$				08
		$				09
		$				10
		$				11
		$				12

*Plan Code	Plan Code Description
F	Flexible Spending Account (FSA)
L	Limited Purpose Flexible Spending Account (LPFSA)

Participant Authorization—By submitting this form to Lifetime Benefit Solutions, I certify that the information here is true and correct.

By submitting this form to Lifetime Benefit Solutions, I certify the information is accurate, the expenses incurred were for myself, spouse or qualified dependents, and these expenses are not reimbursable under any other plan coverage. In addition, I have read the Reimbursement Request Instructions on the following page and agree to adhere to all terms specified. I understand if I do not follow the instructions my reimbursement may be delayed or denied.

- **Mail to:** Lifetime Benefit Solutions, Claims Dept, PO Box 211126 Eagan, MN 55121 or
- **Fax to:** 877-256-7228.
- Call **Customer Service** with questions at 800-327-7130.

Reimbursement Request Instructions

For All Account Types (FSA, HRA, Parking/Transit, RRA, Insurance Premium)

- For faster reimbursement processing you may be able to submit your claims online at **www.lifetimebenefitsolutions.com**.
- Complete the top section, including Social Security Number or Employee ID.
- Submit one expense (either a product or service) per row, even if items are contained on the same receipt.
- Label the receipts to correspond to the Claim Ref #.
- If you have more items than the form can accept, use additional forms.
- Do not "lump" or group items together or write See Attached.
- All claims are subject to deadlines, as defined in your Summary Plan Description (SPD).
- The expenses you submit must qualify as valid expenses under the terms of the Plan, and the claimant receiving the services must be a qualifying individual as defined in the Plan.
- Retain a copy of the Reimbursement Request Form and receipts for your own personal records
- Call Lifetime Benefit Solutions Customer Service with questions at (800) 327-7130 during standard week-day business hours.
- Mail OR fax (but not both!) completed form with required documentation to:

  Lifetime Benefit Solutions Claims Dept.
  PO Box 211126
  Eagan, MN 55121
  Fax # (877) 256-7228

Reporting Medical Mileage

- Medical mileage rates are set by the IRS and can be applied to transportation primarily for and essential to medical care.
- Indicate the total number of miles incurred with each service provided (i.e. round trip miles to visit the doctor).
- Lifetime Benefit Solutions will apply the current mileage rate and include the mileage amount in your total reimbursement.
- You may be required to produce additional documentation for each mileage expense you claim.

Medical Claims for FSA and LPFSA

- For each medical claim covered by your insurance carrier, submit an Explanation of Benefits (EOB). If your claims are not submitted to your insurance carrier, provide an itemized bill showing: date of service, provider name, patient name, charged amount, and description of services rendered.
- Do not send credit card receipts, original receipts or cancelled checks.
- The IRS states that Over-the-Counter (OTC) items classified as drugs and medicine are only eligible if they are accompanied by a doctor's prescription.

Dependent Care Claims

- Please use the separate form titled Dependent Care Account Reimbursement Request Form.